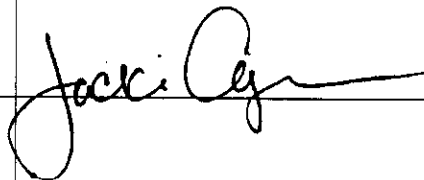


**AFFIDAVIT**

1. My name is Jacki Coyer and I have worked for Attorney Lafayette since April of 2001.
2. I am currently a legal assistant enrolled in a paralegal certificate program.
3. Between the dates of June 10, 2004 and June 21, 2004 our office filed 84 documents, including new petitions, electronically with the United States Bankruptcy Court.
4. I electronically filed 50 of the 84 proceedings, including some of the weekend filings.
5. The 84 filings represent 29 clients Bankruptcy matters. The documents that I filed were approximately 20 of the 29 client's proceedings.

This information is true and correct to the best of my information and belief.

Signed under the pains and penalties of perjury this 2<sup>nd</sup> day of November, 2004.

A handwritten signature in black ink, appearing to read 'Jacki Coyer', is written over a horizontal line.

## TO BE COMPLETED BY HEALTH CARE PROVIDER

CLINICAL DIAGNOSIS: polyneuropathy (Required)DURATION (circle one): Temporary Permanent  
If temporary, please state # of months \_\_\_\_\_

PLEASE CHECK ALL THAT APPLY:

- ☒ Unable to walk 200 feet without assistance (clinical diagnosis **MUST** be completed)
- \_\_\_\_\_ Legally Blind\* (Cert. Of Blindness may substitute for professional certification) (\*automatic loss of license)
- \_\_\_\_\_ Chronic Lung Disease  
Please state FEV1 Test results \_\_\_\_\_ O2 saturation with minimal exertion \_\_\_\_\_  
Use of Portable Oxygen? Yes \_\_\_\_\_ No \_\_\_\_\_
- \_\_\_\_\_ Cardiovascular Disease  
AHA Functional Classification (circle one): I II III IV\*  
(\*automatic loss of license)
- \_\_\_\_\_ Arthritis (please state type, severity, and location) \_\_\_\_\_
- \_\_\_\_\_ Loss of or permanent loss of use of a limb  
Description of functional disability \_\_\_\_\_

HEALTHCARE PROVIDER **MUST** CHECK ONE:

In my professional opinion and to a reasonable degree of medical certainty:

- ☒ The above condition, or any other medical condition of which I am aware, **WILL NOT IMPAIR** the safe operation of a motor vehicle.
- ☐ The person applying for this permit is **NOT** medically qualified to operate a motor vehicle safely.
- ☐ The medical condition as stated above is of such severity as to require a **COMPETENCY ROAD TEST**.

CERTIFICATION: (Please Print)

Michael R. Sorrell, M.D.  
Healthcare Provider's Name  
300 Carew Street, Suite 2 Title  
Address Springfield, Massachusetts 01104

56495  
Mass Board of Registration. #

Telephone Number 415-181-5050  
Healthcare Provider's Signature

6-3-04  
Date

052572 7884  
 SPRINGFIELD NEUROLOGY ASSOCIAT  
 300 CAREW STREET  
 SPRINGFIELD MA 01104

## STATEMENT

9251  
 B5392X  
 TU14  
 BNS 010  
 1537 R

ADDRESS SERVICE REQUESTED

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT	
<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> VISA
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

FRANCIS LAFAYETTE  
 P O BOX 1020  
 PALMER, MA 01069-4020

REMIT TO: SPRINGFIELD NEUROLOGY ASSOCIAT  
 300 CAREW STREET  
 SPRINGFIELD, MA 01104-2316

PLEASE RETURN THIS PORTION WITH PAYMENT

Office Phone Number (413) 781-5050	Statement Date 09/13/04	Your Account Number 7884	Page No. 01	New Balance 433.00	SHOW AMOUNT PAID HERE \$
---------------------------------------	----------------------------	-----------------------------	----------------	-----------------------	-----------------------------

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
071503	SORRELL MD	CPT: 95861 MUSCLE TESTING, TWO EXTREM F LAFAYETTE		245.00		245.00
071503		CPT: 95900 NERVE CONDUCTN TEST EA NERVE MOTOR W/O		220.00		465.00
071503		CPT: 95904 NERVE CONDUCTN TEST, EA NERVE, SENSORY		400.00		865.00
071503		CPT: 95934 H-REFLEX TEST, GASTROCNEMIUS MUSCLE		130.00		995.00
071503		CPT: 95903 NERVE CONDUCTN TEST EA NERVE MOTOR W/T		660.00		1655.00
072403		VISA/MASTECARD PAYMENT, THANK YOU			-300.00	1355.00
101503		VISA/MASTECARD PAYMENT, THANK YOU			-225.00	1130.00
010604		#527241234 PERSONAL CHECK, THANK YOU			-113.00	1017.00
021004		826610329 PERSONAL CHECK, THANK YOU			-113.00	904.00
030904		919961842 PERSONAL CHECK, THANK YOU			-113.00	791.00
040504		CK871524381			-113.00	678.00
051104		CK#870530959			-113.00	565.00
061704		CK 731405901			-113.00	452.00
070704		CK 710245433			-113.00	339.00
081104		CK 171466392			-113.00	226.00
090904		CK 042017205			-113.00	113.00
041404	SORRELL MD	CPT: 99214 OFFICE/OUTPATIENT VISIT, E F LAFAYETTE		160.00		273.00
060304	SORRELL MD	CPT: 99214 OFFICE/OUTPATIENT VISIT, E F LAFAYETTE		160.00		433.00
		PERSONAL PAYMENTS RECEIVED SINCE 08/14/04		113.00		

BILLING DEPT OPEN MON-FRI 1:30PM TO 4PM

Statement Date: 09/13/04	PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 7884					
CURRENT	30-60 DAYS	60-90 DAYS	> 90 DAYS	TOTAL	INS PENDING	NEW BALANCE PAY THIS AMOUNT
			433.00	433.00	0.00	433.00
SEND INQUIRIES / PAYMENTS TO:			(413) 781-5050			
SPRINGFIELD NEUROLOGY ASSOCIAT 300 CAREW STREET SPRINGFIELD MA 01104						

SPRINGFIELD NEUROLOGY ASSOCIATES, LLC  
MICHAEL R. BORRELL, M.D., F.A.A.N.  
EMILIO MELCHIONI, M.D.  
PRES. IP H&L, M.D.  
AMY PODWORSKI, P.A.-C  
300 CAREW STREET  
SPRINGFIELD, MA 01104  
(413) 781-8060

NAME \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

Rx ILLEGAL IF NOT SAFETY BLUE BACKGROUND

R

Charcot - Mame - Tooth  
Disease

Refill \_\_\_\_\_ times

SIGNATURE \_\_\_\_\_

PLEASE PRINT NAME \_\_\_\_\_

Interchange is mandated unless the practitioner writes  
the words "NO SUBSTITUTION" in this space.



3ONE0025174



**Wing Memorial**  
Hospital and Medical Centers

A Member of  
UMass Memorial Health Care

**FOLLOW UP TO YOUR RECENT DIAGNOSTIC TESTS OR RECENT PROCEDURE(S)**

DATE: 6-24-04

PATIENT: Francis Lafayette

MR# \_\_\_\_\_

**LAB TEST RESULTS:**

**X-RAY RESULTS:**

**MAMMOGRAM:**

**PAP SMEAR:**

Prostate cancer screening test normal  
Diabetes control: Not good -  
not, not surprising. Will  
recheck in several months

**BASED ON THIS INFORMATION:**

- ☐ NO FURTHER TESTS ARE REQUIRED AT THIS TIME  
☐ STAY ON YOUR CURRENT MEDICATION  
☐ CHANGE YOUR MEDICATION AS INDICATED: \_\_\_\_\_

- ☐ ARRANGE FOR THE FOLLOWING: \_\_\_\_\_

**SINCERELY:**

Amesur/Inne

MD

**WING MEDICAL CENTER AT:**

- ☐ BELCHERTOWN, tel. 323-5118 fax: 323-6158  
20 Daniel Shays Highway, Belchertown, MA 01007  
☐ LUDLOW, tel. 589-0583 fax: 583-5239  
34 Hubbard Street, Ludlow, MA 01056  
☒ MONSON, tel. 267-9101 fax: 267-4606  
2 Main Street, Monson, MA 01057

- ☐ PALMER, tel. 284-5400 fax: 284-5194  
40 Wright Street, Palmer, MA 01069  
☐ WILBRAHAM, tel. 596-3455 fax: 596-2961  
2344 Boston Road, Wilbraham, MA 01095  
☐ Griswold Center, tel. 284-5285 fax: 284-5384  
40 Wright St., Palmer, MA 01069

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750-1014 11/03

01027



**Wing Memorial**  
Hospital and Medical Centers  
A Member of  
UMass Memorial Health Care

**FOLLOW UP TO YOUR RECENT DIAGNOSTIC TESTS OR RECENT PROCEDURE(S)**

DATE: 8/4/04

PATIENT: Francis Lafayette

MR# \_\_\_\_\_

LAB TEST RESULTS:

X-RAY RESULTS:

MAMMOGRAM:

PAP SMEAR:

There are degenerative changes but no serious findings.

**BASED ON THIS INFORMATION:**

- ☐ NO FURTHER TESTS ARE REQUIRED AT THIS TIME  
☐ STAY ON YOUR CURRENT MEDICATION  
☐ CHANGE YOUR MEDICATION AS INDICATED: \_\_\_\_\_

- ☐ ARRANGE FOR THE FOLOWING: \_\_\_\_\_

**SINCERELY:**

D. Maguire / VZ

MD

**WING MEDICAL CENTER AT:**

- ☐ BELCHERTOWN, tel. 323-5118 fax: 323-6158  
 20 Daniel Shays Highway, Belchertown, MA 01007  
☐ LUDLOW, tel. 589-0583 fax: 583-5239  
 34 Hubbard Street, Ludlow, MA 01056  
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**Wing Memorial**  
Hospital and Medical Centers

A Member of

UMass Memorial Health Care

FOLLOW UP TO YOUR RECENT DIAGNOSTIC TESTS OR RECENT PROCEDURE(S)

DATE: 10/18/04

PATIENT: Francis Lafayette

MR# \_\_\_\_\_

LAB TEST RESULTS:

X-RAY RESULTS:

MAMMOGRAM:

PAP SMEAR:

Blood sugar was (242) too high.  
The over all diabetes control test  
was better. But as you know  
we have a ways to go.

BASED ON THIS INFORMATION:

- ☐ NO FURTHER TESTS ARE REQUIRED AT THIS TIME  
☐ STAY ON YOUR CURRENT MEDICATION  
☐ CHANGE YOUR MEDICATION AS INDICATED: \_\_\_\_\_

- ☐ ARRANGE FOR THE FOLOWING: \_\_\_\_\_

SINCERELY:

Onagure/mmc

MD

WING MEDICAL CENTER AT:

- ☐ BELCHERTOWN, tel. 323-5118 fax: 323-6158  
20 Daniel Shays Highway, Belchertown, MA 01007  
☐ LUDLOW, tel. 589-0583 fax: 583-5239  
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750-1014 11/03

01027

**P87352008**

**Disabled Persons  
Parking Identification Placard**



LAFAYETTE  
FRANCIS  
JOSEPH

**Expires:**

**08-31-09**

**Commonwealth of  
Massachusetts**